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M e m o r a n d u m

To: Tara Hupp, Administrator
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Date: February 7, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

The Operation Guardians team conducted a surprise inspection of Sunrise Convalescent Hospital in Pasadena, on December 14, 2011. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. During the inspection at 8:00 AM, Resident 11-05-01, residing in Room 5B, was observed receiving gastrostomy tube feedings via a pump delivery system. The head of his bed was elevated approximately 35 degrees, but the resident was lying down towards the bottom of the bed causing his head to only be elevated approximately 15 degrees. The call light was illuminated by the Operation Guardians (OG) nurse and staff arrived to reposition the resident. The position the OG team found this resident in could cause the resident to aspirate while he was receiving the gastrostomy tube feedings.

2. Resident 11-05-02 was also observed receiving gastrostomy tube (GT) feedings via a pump delivery system. The resident was lying down towards the bottom of the bed causing her to also be at risk for aspiration, secondary to poor positioning. The resident's hospital gown was observed to be stained at the site where the GT entered the abdomen. The OG nurse raised the resident's gown to find a heavily soiled GT dressing with thick yellow/green drainage. The OG nurse located a licensed nurse to assess the GT dressing, the site and the drainage. The licensed treatment nurse arrived at the resident's bedside and started to remove the saturated dressing. The OG nurse inquired about the yellow/green purulent appearing drainage and the treatment nurse responded *"I will check the tube for placement because it looks like tube feeding to me."* The dressing appeared to the OG nurse as if the resident had not been receiving routine GT site cleaning and had a possible infection. If the site was not infected as it appeared, the resident probably required the GT site to be cleaned more frequently than once a day. The treatment nurse reported the resident was to be wearing an abdominal binder because she (resident) would pull at the tube. The OG nurse and another staff member searched the resident's bedside and closet for the abdominal binder. No binder was located. The treatment nurse was later observed entering the resident's room with an abdominal binder.

Review of the resident's chart showed there was no physician order for an abdominal binder or a Care Plan implemented by the nursing staff. The chart also indicated the resident had several

issues with the GT being clogged or having been pulled out. Chart documentation also indicated on November 27, 2011, the granddaughter called to say the family did not want the GT replaced and the grandmother (resident) did not want the GT replaced. The tube was replaced anyway at Silver Lake Hospital. There was no documentation tha the facility had implemented a case conference to discuss the GT replacement with the family and the plan for possible future GT replacements, according to the resident's and family's wishes.

The resident appeared to be developing contractures to her ankles and knees. On November 21, 2011, the resident was ordered "RNA Program" to bilateral upper and lower extremities. The team did not observe any range of motion exercises administered to the resident during their inspection time.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. Upon entrance to the facility, and throughout the team's walk-through, the team observed the facility as being extremely dirty, heavily soiled. There were many items in disrepair throughout the facility's second floor, where the residents reside. The building's excessive ground-in dirt and debris appeared to be in existence for an extended period of time and could not be classified as usual "housekeeping issues." The condition of the facility was not in compliance with Title 22, §72637. General Maintenance and Title 22, §72621. Housekeeping.

   Some of the serious maintenance issues the team identified were:

   - A light shield was missing from a ceiling light in the entryway of the facility.
   - Debris was on floors throughout the facility including resident rooms.
   - Windows throughout the facility were dirty.
   - A heavily soiled crash cart was observed in the clean utility room.
   - A soiled bedside commode was stored on the clean side of the utility room.
   - The faucet was corroded in the clean utility room.
   - The bathtub room had a heavily soiled tub filled with debris. Several metal chairs with black upholstery and a bedside commode were also in the tub and it appeared the items had simply been throw in the tub. The room also had decaying wall plaster, debris on the floor, missing tiles and baseboards.
   - The beauty salon was cluttered and unorganized. The team observed drying paint in a metal pan with a paint roller that appeared to have been previously utilized.
   - The blinds on the window in the beauty salon were broken.
   - The residents' bathrooms smelled of urine. The bathroom of Room 7 was observed with feces on the toilet seat and holes in the wall where perhaps a receptacle was once attached to the wall. The three holes in the wall were in need of repair.
   - The shower rooms were heavily soiled with feces and mold. The rooms also had a strong musty odor. Mold was observed on the shower room ceilings, shower curtains were soiled, black mats on the shower floors were worn and drains were filled with debris and feces.
   - Resident's furniture, such as drawers in the nightstands were broken and in need of repair.

- Walls were observed with chipped paint and damaged plaster.
- Doors were observed with deep areas of scuffed wood.
- Resident's linen was dingy in color.
- Resident rooms did not have name plates outside the door.

3. During the team's walk-through of the facility it was noted the building's temperature was cool. Several residents complained to the team they were cold and uncomfortable and they stated it was always cold. Residents were observed without blankets on their beds and several of these residents were aphasic and could not ask for assistance. The team requested the facility staff to provide blankets for the residents. The linen closets contained minimal linens and blankets for the residents.

4. The Beauty Salon's door was unlocked and contained a chaotic disorganization of activity supplies, holiday supplies, and stacks of boxes overflowing with unidentifiable items. The supplies were overflowing in boxes, on metal shelves and carts stacked unsafely throughout the room. It was impossible to enter the room due to the disorganization. The white cupboards were open and accessible to the residents. On the floor was an open can of paint and a metal container with a paint roller. The container contained drying paint. The team nurse asked a staff person how the room was utilized for hair styling. She reported all the items in the room were removed to make access to the salon area. It appeared the styling chair, sink and supplies had not been utilized for the residents in a long time. The room was a safety hazard for residents that may wander and it was clear that the Beauty Salon was not being utilized for the residents's use.

5. Several residents were observed by the OG team with their call lights out of reach. This is a potential neglect issue.

6. Several residents were observed exposed while being transferred by chairs to the shower rooms. The white bath blankets were not appropriately draped and secured for the residents to prevent unnecessary exposure. This was brought to the attention of the certified nurses assistants (CNA). This is a Resident Rights, and dignity issue.

7. There were several rooms that did not have the names of the residents posted outside the rooms. This is a potential safety issue.

ADMINISTRATIVE OBSERVATIONS:

1. The facility's most current Department of Health survey was not posted for the public to review, as required by Title 22.

2. The team's review of the Incident and Accident Log was found not to be complete. The OG team was aware of several incidents that had occurred at the facility, but when reviewing the Incident/Accident log, these incidents were not logged in. And, the team was not able to locate copies of SOC forms that had been filled out on these incidents. State law requires all instances of suspected abuse or neglect to be reported to the Ombudsman and the Department of Public Health.

3. Residents expressed concern about several issues. Some residents stated that they did not get their medications on time or when they requested them and several residents said that they had belongings that were missing or stolen. Several residents also expressed that the night shift "doesn't help them and the night shift's attitude is bad and they don't help us eat when we need to eat." Additionally, several residents mentioned they don't get their food at night, or snacks.

4. The facility was utilizing "Queen of Angels Hospice" services for **all** eight hospice residents. The team was informed during the inspection the hospice company was also owned by the owners of the facility. It was not clear if the residents were given a choice for a hospice company or if this was the **only** contracted hospice agency the facility had on file.

4 The bulletin boards in the hallways contained photographs of residents taking part in activities and social functions provided by the facility and outside vendors. It was unclear if the facility had received authorization by the residents, their families, conservators or guardians to be posting the photographs. Several of the social functions appearing in the photographs seemed inappropriate for the facility residents. Regulations require residents to give permission before having their photographs used for any purpose other than identification.

5. Many of the facility residents did not appear to meet the level of care requirements for 24-hour skilled nursing care. The facility should be actively planning to discharge residents not meeting the skilled nursing level of care, per Title 22, to a lower level care of service. The team's review of the social services documentation for many of the residents did not indicate discharge planning was being implemented by the facility.

6. The ice cream parlor room located on the first floor was a festive decorated area. The only persons accessing the room were the facility staff observed eating their lunch.

7. The downstairs' desk located in the entry area of the facility was unoccupied during the entire time the OG team was at the facility. This was of concern as many residents in the facility were ambulatory. The facility did not have alarms on the facility exit doors or any wander guards. One resident was sitting by the front door waiting for her ride home, and no one was there to monitor her departure, who she left with or when. When reviewing the resident's chart, it was noted the resident was on hospice and went out frequently for home visits. Unattended residents were observed walking off the elevator and going out the first floor entrance door without anyone on the first floor noticing they were leaving. This facility had a previous tragedy when a resident went outside and the facility needs a better monitoring system. The lack of supervision and monitoring of the residents is a serious safety concern.

8. While reviewing the resident's medical charts, the team determined several of the residents were conserved but the facility was having the resident sign consents in place of the conservator. Several other residents did not have the capacity to make decisions and the facility staff had become their decision maker. These issues need immediate attention, The facility needs to comply with state law as it relates to the role of conservators and their decision making duties.

9. During the Operation Guardians inspection, it was observed that the facility was providing care for 12 gastrostomy tube residents. These residents require a higher level of nursing care due to the involvement of time required by a licensed nurse to administer the nutritional support,

administer medications, provide supplemental hydration and check for tube placement. According to the staffing calculation by Operation Guardians (see below), the residents who had gastrostomy tubes may not have been provided with the appropriate licensed skilled nursing hours for the acuity of the residents.

10. The facility's Policy and Procedure for Reporting Elder and Dependent Adult Abuse, is not in compliance with state law. State law requires that all employees are mandated reporters and as such are required by law to report all suspected instances of suspected elder abuse or neglect to the Long-Term Care Ombudsman or to law enforcement, and to follow-up with the submission of an SOC 341 form to the Ombudsman's office. The facility Administrator is not to serve as the investigative authority and to make the reports, it is the individual's responsibility. Failure to report is a misdemeanor and it is recommended that the facility review the Department of Justice mandatory training program for all long-term care employees, entitled, "Your Legal Duty..How to Recognize and Report Elder and Dependent Adult Abuse."

STAFFING:

Based on the records provided by the facility, staffing levels were **below** the 3.2 hours per resident day (hprd) on **ALL six** days randomly reviewed. **The average hprd was 2.96 hours.**
It should be noted the Minimum Data Set (MDS) registered nurse's (RN) time did not appear on the Time/Attendance Detail Report. However, even with the additional calculated MDS hours, the facility still would not have been in compliance with the 3.2 hours hprd. Also, according to the Time/Attendance Detail Report, there was no RN on duty for the days of 10/16/11, 11/25/11 & 11/26/11.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. If you have any questions or any comments, please contact Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
February 8, 2012

Sunrise Convalescent Hospital
December 14, 2011

The care of twelve current and former residents was evaluated. This nursing facility serves a mixed population of high-acuity elderly residents and younger, more independent ones. Deficient care and processes of care have avoidably harmed both types of residents.

I. Elopements, passes, and residents' decisional capacity

The physical layout of the building is such that any resident can easily the facility unseen in a number of locations, and the facility lacks a Wanderguard-type system to alert staff when a resident elopes or attempts to elope. Some of the younger, more independent residents *may* possess the capacity to understand the potential risks and hazards to them outside the facility, but each is vulnerable to harm when leaving the home unescorted. The majority of these residents are incapable of self-preservation.

The facility may allow residents to leave on a "pass," in which case there needs to be a physician's order authorizing the leave as well as an assessment of the safety of the resident outside the facility. In the case of Resident 4, she was allowed to leave the facility on multi-day passes with no physician's order allowing her to do so. The resident has diagnoses of Alzheimer's disease with psychosis and has been prescribed an antipsychotic drug. In order for the facility to ascertain that it was safe for Resident 4 to be in someone else's care and custody for days at a time, there needed to be an assessment of the responsible caregiver(s), evidence that she/he/they had been educated about the drugs Resident 4 had been prescribed, the side effects and precautions associated with them, No such assessments or documentation about family education (or a care plan for same) were found in the record. This resident is at risk for significant adverse outcomes as a consequence of the facility's deficient practice.

There does not appear to be any mechanism in place for the facility to determine whether a resident possesses decisional capacity. In some cases, the face sheet listed a family member as the "responsible party," which implies that the family member was the decision-maker, while consent documents were signed by the resident. It does not appear that the attending physicians are actually conducting examinations in order to tell the facility whether or not the resident has capacity. The standard requires that it is the physician who determines capacity, and the facility should have a system in place to ensure compliance, yet lacks one at the present time.

In the case of Resident 3, as was discussed with the Administrator and Director of Nurses at the conclusion of our inspection, he had not been determined to possess capacity and was allowed to exit the building at will. On at least one recent occasion, he returned to the facility with alcohol on his breath. This man, age 45, had suffered a traumatic brain injury in June 2011, but was virtually independent in all of his activities of daily living and according to a recent Minimum Data Set assessment had intact cognition (Brief Interview for Mental Status score 15/15). Thus, it was unclear why he needed nursing facility care at all. If it was on the basis of impaired abilities related to the prior TBI, there was no documentation of it.

In one facet of the facility's care of Resident 3, it appears they believed him to lack capacity: they got another person to sign the consent for a new prescription of an anti-anxiety drug, Clonazepam (Valium-like tranquilizer). The drug was prescribed for anxiety manifested by "constant restlessness" (precipitated by the frequent elopements?), and the consent was signed by an individual who was not authorized to make decisions on the resident's behalf (she was his social worker at Rancho Los Amigos after his initial TBI). This class of drugs is known to increase fall risk, and considering that Resident 3 had fallen and suffered a small brain hemorrhage as a result about a week, before made the consent process even more important. It was an extreme departure from prevailing standards of quality for the facility to have accepted consent from anyone other than the resident himself or a legal surrogate.

II. Advance directives and end of life care

The process for assessing and honoring a resident's preferences for life-sustaining treatment and end of life care also requires that either a capable resident makes his or her own choices or chooses to allow a surrogate to make them. Or, an incapable resident's surrogate determines what type of care should be provided. However, in a number of cases reviewed, residents lacking capacity were signing their own POLST (advance directive) forms.

For example, Resident 3, presumed to lack the capacity to sign his own consent for Clonazepam, signed his POLST form. According to her face sheet, Resident 1's daughter was the designated responsible party, yet the resident herself signed the POLST; the attending physician determined that her decisional capacity was "fluctuating". Resident 6's daughter was her responsible party; she signed her own POLST. The failure of the facility to ensure that: a) residents' decisional capacity is routinely and accurately assessed; b) legal documents such as consents and POLST forms are signed by the resident or legal surrogate; and c) the contents of such documents are explained to the resident/surrogate and acted upon appropriately constitutes a seirous violation of generally accepted standards of quality.

In addition, in at least two instances, including one on the day of our inspection, facility nursing staff appeared to disregard the advance directive memorialized on the POLST form. Resident 12's legal surrogate had signed the POLST which stated that the resident was to receive CPR and all other life-sustaining treatment. However, on the morning of

our visit, he was observed in bed with audible congestion and a severely low oxygen saturation level. Despite the fact that he requested full treatment, facility staff, who were aware of his condition, did not summon emergency medical services until instructed by myself to do so. Interview with nursing staff indicated that he was noted to have had a change of condition at 5:30 am (or earlier) and at that time his blood pressure was abnormally low. The resident was receiving tube feeding, and the feeding pump had been infusing formula all night according to the display on the pump. It appeared to me as though the resident had aspirated, at a minimum, and may well have been systemically ill from aspiration pneumonia. Review of the 24-hour communication log showed that the nurse on the shift ending at 7 a.m. that day had written that Resident 12 had been "coughing all night" and his blood sugar reading was "HI" (greater than the upper limit of the machine, which is typically 500). This case demonstrates not only nursing neglect, but a violation of the resident's right to the treatment specified in the POLST.

Resident 11 was admitted to the facility on 11/7/11 and died in the facility on 11/20. Her son signed her POLST on 11/8, which stated that she was to receive CPR and full life-sustaining treatment. She had been admitted to a hospice agency on 11/10 but I did not find a physician's order rescinding these directives. The resident was receiving tube feeding and other life-sustaining interventions. One week before her death, a nurse documented that the enteral feeding was observed extruding from the gastrostomy tube site—an indication of possible displacement of the tube; at a minimum, it was an indication that the tube was malfunctioning. However, there was no documentation that the resident's doctor was informed of this change in her condition, and no follow-up notes are present in the chart. On the day of her death, she vomited "black, tarry" material and was found dead about 6 hours later, with no intervening treatment. Likely it was a complication of her G-tube that led to her demise—a potentially treatable condition that nursing staff ignored, in addition to having ignored her advance directive.

The nursing facility owners also own the hospice agency serving residents at the facility. In several other cases, there was an absence of hospice involvement and no documented coordination of care between hospice and facility nursing staff.

Resident 2 was suffering from metastatic breast cancer and was being served by the hospice agency. When she suffered from bouts of chest pain on 11/8 and 11/30, she was transferred to the emergency department, and on the latter occasion she was admitted to the hospital for treatment. Review of the nursing notes shows that the hospice agency was not contacted about her change in condition on 11/30, but rather her attending physician was called and ordered the transfer. After the fact, the hospice agency stated that she "revoked" the hospice benefit, however; there is no documentation supporting that statement, as hospice hadn't been contacted prior to the transfer. In this type of case, the nursing facility is required to coordinate care with hospice, and the hospice agency should always be called first when there is a change in resident condition. That way, the hospice providers have an opportunity to assess the resident and determine with the resident what the course of treatment should be. The resident was needlessly shuffled out of the facility due to this failure of care. This resident was an undocumented immigrant,

so the costs of these episodes will be borne by the treating hospitals rather than the nursing facility or the hospice agency.

One resident who died recently in the facility was reviewed. Resident 5 was admitted to hospice on the day of his admission and died at the facility the next day. There was no documentation by any hospice nurses in the nursing facility record, and nursing facility nurses failed to chart on the man's condition for extended periods. There was no narrative charting concerning his condition or comfort level between 2 am and 10:45 am, between 10:45 and 3:30 pm, and between 3:30 and 7:30 pm when he was found dead. He had been admitted with confusing orders for morphine; one said it was to be given every 3 hours subcutaneously and the other said to give it every one hour sublingually, but there was no documentation regarding how these orders were carried out. It is not possible to determine whether any of the treatment provided to this man was effective in alleviating his suffering as he died because of the absence of documentation. Dying persons require intensive nursing care and documentation, which was lacking in this case. Hospice did not appear to have been involved at all.

III. Nursing processes of care, assessments and monitoring

The nursing director had been hired within the past year and has instituted a number of changes, according to an interview with her. She has been attempting to heighten nurses' "critical thinking" skills, and has terminated some long-term nurses and hired new ones. Several commendable processes were evident, including having CNAs conduct daily body audits for residents at risk for skin breakdown, and having nurses chart accurately about resident condition rather than by "rote". It does not appear that there is an excess of avoidable pressure sores at the present time, and many examples of very good nursing documentation were seen in resident charts. However, there appears to be insufficient supervision of nursing staff at the present time, as demonstrated by some of the examples described above. Insufficient supervision included failures to follow through on changes of condition; nurses' failures to consult POLST forms; and nurses failing to keep physicians and families informed about changes in condition.

Nursing assessments were not always completed timely. For example, Resident 9 suffered a fall in the early morning hours, was transferred to an acute care hospital and died almost immediately, apparently from either an injury or from a condition—unrecognized at the facility—which caused him to fall that morning. Fall risk assessments were not completed accurately and had not been updated quarterly; there was no care plan addressing his fall risk. Resident 8 suffered a life-threatening episode of low blood sugar after being started on insulin for the first time. There are no nursing assessments of his meal intake during the initial days of beginning insulin therapy, in violation of standard nursing care. Absence or failure of nursing assessment is another hallmark of insufficient supervision, and also of insufficient staffing.

Monitoring by licensed nurses needs improvement. When a resident is noted to have a change in condition and new interventions are implemented, nurses need to monitor on a shift by shift basis, yet the examples above demonstrate that monitoring is deficient at the

present time. The use of 24-hour communication logs is helpful in ensuring continuity of monitoring, but only if the information is acted upon.

Turnover in the nursing director role, while sometimes necessary and appropriate, poses the risk that nursing services deteriorate while changes are being made. The time frame for staff to conform to new expectations can be considerable. Under these circumstances, the home must carefully evaluate its staffing patterns to ensure that sufficient numbers of adequately trained and supervised nursing staff are available to meet the needs of each resident. It appears that this nursing facility is still in a phase where nursing staff need more help and support to meet the expectations of the relatively new nursing director. It does not appear that staffing of the nursing department at the facility is sufficient in this context.

In conclusion, quality of care at this facility needs improvement to avoid further avoidable harm to residents. Systems need to be implemented and/or strengthened to ensure that residents' capacity determinations are complete and accurate, that advance directives are honored, and that the nursing staff are adequate to meet the skilled nursing care needs of every resident.